

BADGERCARE+

Training Sessions for Dental Providers

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BadgerCare Plus Overview

BadgerCare Plus Overview:

- Introduced in 07-09 biennial budget proposal.
- Expansion of health care coverage to Wisconsin residents.
- Program begins February 1, 2008.

BadgerCare Plus Overview (cont.)

Key Initiatives:

- Ensure that all Wisconsin children have access to affordable health care.
- Ensure that 98% of Wisconsin residents have access to health care.
- Streamline program administration and enrollment rules.
- Expand coverage and provide enhanced benefits for pregnant women.
- Promote prevention and health behaviors.

BadgerCare Plus Overview (cont.)

Enrollment Expansion:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

BadgerCare Plus Overview (cont.)

BadgerCare Plus is the merger of the following programs:

- BadgerCare.
- Healthy Start.
- Family Medicaid.

BadgerCare Plus Overview (cont.)

BadgerCare Plus has two benefit plans.

Standard Plan covers the following people with incomes at or below 200% of the Federal Poverty Level (FPL):

- Children.
- Parents and caretaker relatives.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Pregnant women.

BadgerCare Plus Overview (cont.)

BadgerCare Plus has two benefit plans.

Benchmark Plan covers the following people:

- Children in families with incomes above 200% of the FPL.
- Pregnant women with incomes between 200% and 300% of the FPL (\$51,510 for a family of 3).
- Certain self-employed parents, such as farmers, with incomes up to 200% of the FPL.

BadgerCare Plus Overview (cont.)

Medicaid covers the following people:

- 65 or older, blind, or have a disability will continue to be enrolled in their respective programs (SeniorCare, Family Care, or Medicaid).

BadgerCare Plus Overview (cont.)

Terminology changes:

- Recipients will now be referred to as members.
- Presumptive eligibility is now referred to as Express Enrollment.
- Medicaid Health Maintenance Organizations (HMOs) will now be referred to as BadgerCare Plus Standard Plan HMOs and BadgerCare Plus Benchmark Plan HMOs.
- Eligibility will now be referred to as enrollment.
- Medicaid will now be referred to as Standard Plan, unless otherwise specified in publications.
- Forward card is now the ForwardHealth card.

BadgerCare Plus Covered Services

New services covered under all plans:

- Over-the-counter tobacco cessation *products* for all members.
- Mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women at risk of mental health or substance abuse problems.

Services covered under the Standard Plan are the same as the current Medicaid program. The term "Standard Plan" will be used going forward to describe shared policy and billing information for Medicaid and Standard Plan.

The Benchmark Plan was modeled after commercial health insurance plans.

BadgerCare Plus Covered Services (cont.)

Certain dental services are covered under the Benchmark Plan only for the following members:

- Children up to 18 years of age.
- Pregnant women.

Coverage under the Benchmark Plan is limited to specific services within the following categories:

- Diagnostic.
- Preventive.
- Simple restorative.
- Periodontics.
- Surgical extraction procedures.
- TMJ — covered the same as the Standard Plan billed by oral surgeon.

TMJ and Traumatic Injury Treatment

Benchmark Plan

- Diagnosis and treatment for TMJ are the same as they are under the current Wisconsin Medicaid program.
- Services provided to children up to age 18 and pregnant women may be covered by a dentist.
- Claims with procedures that are not identified as covered services will need to be reviewed by a dental consultant for possible reimbursement as a traumatic injury-related service.

Prior Authorization

Policy and procedures are the same for all BadgerCare Plus plans.

Claim Submission Requirements

The claim submission requirements for the BadgerCare Plus Standard Plan and Benchmark Plan are the same as they are under the current Wisconsin Medicaid program.

Reimbursement

Providers should always bill their usual and customary fees.

Standard Plan:

- Current maximum allowable fee schedule.

Benchmark Plan:

- Max fees are set at the 50 percentile of ADA 2005 survey of dental fees – East North Central region.
- Dental services 50% allowable charges.

Copayments

Medicaid:

- No change in copayment amounts.

Providers cannot collect copayments from the following Medicaid members:

- Nursing home residents.
- Pregnant women.
- Members under 18 years of age, including children who are members of a federally recognized tribe. (For HealthCheck services, members under 19 years of age are exempt.)
- Members enrolled in Medicaid SSI HMOs or Medicaid special managed care programs.

Copayments (cont.)

Standard Plan:

Providers cannot collect copayments from:

- Nursing home residents.
- Pregnant women.
- Members under 18 years of age with incomes at or below 100% of the FPL.
- Members under 18 years of age who are members of a federally recognized tribe regardless of income.

On February 1, 2008, Standard Plan members **are subject to copayment** for services where copayment applies:

- Members enrolled in BadgerCare Plus Standard Plan HMOs.
- Members under 18 years of age with incomes above 100% of the FPL.

Cost Sharing

Benchmark Plan

Deductible: \$200.00 per member per enrollment year

Coinsurance: 50% of fee schedule

Copayment: \$0.00

Service Limit: \$750.00 per member per enrollment year

Exception:

- Pregnant women are exempt from deductible and coinsurance.
- Native American children are exempt from deductible and coinsurance.
- Preventive and diagnostic services are exempt from the \$200.00 deductible.

The \$750.00 service limitation is per enrollment year. Any services provided after the \$750.00 service limitation has been exhausted are considered noncovered services.

Cost Sharing Examples

Each member is responsible for a \$200 deductible per enrollment year for all covered services. Once the deductible is met, reimbursement is 50% of the allowable charges for each service up to a \$750.00 limit per member per enrollment year.

Preventive and diagnostic services are only exempt from the deductible.

Cost Sharing Examples (cont.)

Example 1:

- Limited exam, \$47.00.
- Panoramic X-ray, \$82.00.
- Periapical X-ray, \$19.00.
- Extraction, \$100.00.

Total \$248.00.

Because the exam and X-rays are considered **preventive and diagnostic**, they are **exempt** from the \$200.00 annual deductible but not from the \$750.00 annual limit. These services are reimbursed by the state to the provider at 50 percent of the maximum allowable fee with the member responsible for the balance. The provider would receive \$23.50 from the state for the limited exam, \$41.00 for the panoramic x-ray, and \$9.50 for the periapical X-ray for a total of \$74.00. The member is responsible for the balance.

Because the extraction is subject to the \$200.00 annual deductible, the member is responsible for the full \$100.00.

Cost Sharing Examples (cont.)

Example 2:

- New patient exam, \$50.00.
- Full mouth x-ray, \$90.00.
- Adult Prophylaxis, \$60.00.
- Restorations, \$313.00.

Total \$513.00.

Because the exam and X-ray and prophylaxis are considered **Preventive and diagnostic**, they are **exempt** from the \$200.00 annual deductible but not from the \$750.00 annual limit. These services are reimbursed by the state to the provider at 50 percent of the maximum allowable fee with the member responsible for the balance. The provider would receive \$25.00 from the state for the new patient exam, \$45.00 for the full mouth X-ray, and \$30.00 for the adult prophylaxis. The member is responsible for the balance.

Cost Sharing Examples (cont.)

Because the restorations are subject to the \$200.00 annual deductible, the member is responsible for the first \$200.00 and then 50 percent of the balance for a total of \$256.50 (\$200.00 deductible plus 50 percent, or \$56.50, of the remainder). The state would pay the remaining \$56.50.

Providers are **not** required to accept members in the Benchmark Plan.

Under the Benchmark Plan, a provider has the right to deny services if the member fails to pay any required cost sharing.

Provider Rights

- As with current policy, providers have a right to limit their practice.
- A provider has the right to deny services if the member fails to pay any required cost sharing.

Billing Members

Policy and procedures for billing Standard Plan and Benchmark Plan members for covered services are the same as they are under the current Wisconsin Medicaid program.

Billing Members for Noncovered Services

Standard Plan

Policy and procedures for billing members for noncovered services are the same under the Standard Plan as they are under the current Wisconsin Medicaid program.

Benchmark Plan

Some services **are never covered** under the Benchmark Plan.

Billing Members for Noncovered Services (cont.)

Benchmark Plan:

- Providers may collect reimbursement for noncovered services from the member if the member accepts responsibility for payment and makes payment arrangements with the provider.
- Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.
- For noncovered services, providers can bill members up to their usual and customary charges.

Billing Members for Noncovered Services (cont.)

Note: The restrictions on billing members for covered services are the same under the Benchmark Plan as they are under Wisconsin Medicaid. Providers are prohibited from collecting payment from members for certain services, such as translation services or missed appointment charges. Providers are also prohibited from collecting payment from members for BadgerCare Plus-covered services that do not meet program requirements.

Enrollment Year

Benchmark Plan enrollment year is defined as:

- Continuous 12-month period.
- Begins the first day of the calendar month in which the Department of Health and Family Services (DHFS) enrolls a member in the Benchmark Plan.
- Ends on the last day of the 12th calendar month.

Note: If a member switches from the Benchmark Plan to the Standard Plan, the Benchmark Plan enrollment year does not reset.

Enrollment Year (cont.)

The Benchmark Plan enrollment year is used to determine service limitations in the Benchmark Plan.

Note: Services received under Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa.

Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.

Enrollment

Simplification:

- Current – over 20 different coverage groups.
- BadgerCare Plus – 3 coverage groups.

Current application process will stay in place. Applications may be submitted in any of the following ways:

- Web: access.wisconsin.gov/access/
- Telephone.
- Mail.
- In person.

Enrollment Verification

Check enrollment:

- For each visit.
- Determine under which plan he or she is covered.
- Before providing services.
- Discover any limitations to the member's coverage.

Enrollment verification options available:

- 270/271 transaction.
- Vendors.
- AVR.
- Provider Services.

Enrollment Verification (cont.)

Enrollment information that is available:

- Limited benefit categories.
- HPSA coverage.
- Lock-in status.
- Member liability.
- Level of care.
- BadgerCare Plus coverage.
- BadgerCare Plus managed care coverage.
- Commercial health insurance coverage.

Enrollment Verification (cont.)

For BadgerCare Plus member enrollment, providers may hear one of the following messages:

- BadgerCare Plus Standard Plan.
- BadgerCare Plus Standard Plan. No copay.
- BadgerCare Plus Standard Plan. No copay. Ambulatory Services. No inpatient services are payable.
- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Benchmark Plan. Dental Benefit.
- BadgerCare Plus Benchmark Plan. No copay. Dental Benefit.
- BadgerCare Plus Benchmark Plan. No copay. Dental benefit. Ambulatory Services, no inpatient services are payable.

Express Enrollment

Express Enrollment:

- Available for pregnant women and certain low-income children.
- Determination made by qualified providers and other community partners (e.g., Head Start; Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]; faith-based organizations; child care centers; schools) for children under the age of 19 with specific income requirements.

Note: At the end of this session, we will be offering training on the ACCESS eligibility system.

Identification Cards

Identification cards are being redesigned; however, current Forward cards are still valid.

ForwardHealth card will be issued:

- Upon request.
- When a card is lost or stolen.
- To new members.

Note: Members of the same family may have cards that look different from one another.

Identification Cards (cont.)

Additional identification cards will continue to be available:

- SeniorCare identification cards.
- Presumptive Eligibility (PE) identification cards from the back of the paper application for pregnant women.
- BadgerCare Plus Express Enrollment identification cards for pregnant women and children.
- Temporary cards (green).

Contact Information

Additional BadgerCare Plus information can be found at the following Web sites:

BadgerCare Plus Web site:

- www.badgercareplus.org
- dhfs.wisconsin.gov/badgercareplus

BadgerCare Plus Updates:

- dhfs.wisconsin.gov/medicaid4/index.htm
